Calendar No. 663

99TH CONGRESS
2d Session

SENATE

REPORT
99-311

NATIVE AMERICAN DIABETES PREVENTION AND CONTROL ACT OF 1986

MAY 29, 1986.—Ordered to be printed

Filed, under authority of the order of the Senate of May 21 (legislative day, May 19), 1986

Mr. ANDREWS, from the Select Committee on Indian Affairs, submitted the following

REPORT

[To accompany S. 1988]

The Select Committee on Indian Affairs, to which was referred the bill (S. 1988) to establish a program for the prevention and control of diabetes among Native Americans, having considered the same, reports favorably thereon with amendments and recommends that the bill (as amended) do pass.

The amendments are as follows:

On page 1, line 4, strike "1985" and insert in lieu thereof "1986".

On page 1, beginning on line 8, strike the following: "(which for purposes of this Act includes Indians, Native Alaskans, and Native Hawaiians)".

On page 2, beginning on line 15, strike the following: "(hereinafter referred to as the 'Department')".

On page 3, line 10, before the word "relating" insert the words "of Health and Human Services".

On page 3, between lines 21 and 22, insert the following:

DEFINITIONS

SEC. 3. For the purposes of this Act—

(1) The term "Native American" means any—

(A) Indian,

(B) member of an Alaska Native village (within the meaning of section 3 of the Alaska Native Claims Settlement Act), or

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(C) Native Hawaiian.

(2) The term "Native Hawaiian" means any descendant of a person who, prior to 1778, was a native of the Hawaiian Islands.

(3) The term "Secretary" means the Secretary of Health and Human Services.

(4) The term "area office" means an administrative entity within the Indian Health Service through which services and funds are provided to the service units within a defined geographic area.

(5) The term "service unit" means—

(A) an administrative entity within the Indian Health Service, or

(B) a tribe or tribal organization operating health care programs or facilities within funds from the Service under the Indian Self Determination Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.

On page 3, line 23, strike "3" and insert "4" and delete the words "of Health and Human Services (hereinafter referred to as the 'Secretary')".

On page 5, line 5, strike "4" and insert "5".

On page 5, between lines 9 and 10, insert the following: "(2) to screen each individual who receives services from the Indian Health Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic;"

On page 5, line 10, strike "(2)" and insert "(3)".

On page 5, line 19, strike "(3)" and insert "(4)".

On page 6, line 1, strike "(4)" and insert "(5)".

On page 6, line 4, strike "(5)" and insert "(6)".

On page 6, line 8, strike "(6)" and insert "(7)".

On page 7, line 19, before the word "Secretary", insert "(1)".

On page 7, between lines 22 and 23, insert the following: "(2) The Secretary shall employ in each area office of the Indian Health Service at least one diabetes control officer who shall coordinate and manage on a full-time basis the diabetes care program of the Indian Health Service in the area served by such area office."

On page 8, line 4, strike "5" and insert "6".

On page 8, line 14, strike "6" and insert "7".

On page 8, line 15, before the word "which", insert the words "of Health and Human Services".

On page 8, line 25, strike "7" and insert "8".

On page 9, line 2, strike "8" and insert "9".

PURPOSE

The objective of the Native American Diabetes Prevention and Control Act is to broaden the research for diabetes and to strengthen the efforts of the Indian Health Service in prevention and treatment of diabetes and its complications in order to raise the health status of Native Americans to the highest possible level.

Background and Need

S. 1988 requires the Indian Health Service to improve and expand its activities to prevent and control diabetes among the Native American population. The goal is to reduce the incidence of diabetes to a rate comparable with that of the general U.S. population.

The bill was based on investigative work conducted by the Select Committee on Indian Affairs, including site visits to the Navajo and Pima Reservations which documented the lack of field resources to prevent and control diabetes. Further, a comprehensive telephone survey was conducted to determine the extent of the disease and the capabilities for treatment and prevention on each reservation. Numerous problems were cited, including: a lack of adequate medical facilities for treatment; patient overcrowding in existing facilities; the dispensing of expired drugs; the lack of a diabetes education program; a high prevalence of diabetes, hypertension, mental health problems and drug and alcohol abuse.

There are 51 IHS hospitals and several hundred clinics serving approximately 1,000,000 Native Americans. Seven model diabetes clinics exist in Oklahoma, North Dakota, Nebraska, New Mexico, Arizona, Maine and Washington, but these only service 10% of the Native population. Statistics indicate that as much as 40% of the Native American population is afflicted by the disease and diabetes is the second leading reason for out-patient visits to IHS facilities. Statistics show a continuous rise of diabetes in the Native American population. The diabetes mortality rate for Native Americans is 19% at an average age of 45–65 years, compared with a 9% mortality rate average for other ethnic groups. Seventy-six percent of the lower extremities amputations and 78% of dialysis patients among Native Americans are attributed to diabetes.

Epidemiologists and researchers are still working to ascertain the primary cause of diabetes mellitus. There is strong evidence, however, to substantiate the higher prevalence of diabetes in the Native American population than in other ethnic groups. A high fat diet and lack of exercise are thought to contribute; in addition, some obese Native American diabetics have developed "insulin resistance" which poses a great challenge for treatment.

Legislative History

S. 1938, the Native American Diabetes Prevention and Control Act of 1986, was introduced by Senator Melcher and six cosponsors on December 19, 1985, and referred to the Select Committee on Indian Affairs. A hearing was held April 15, 1986.

A companion bill, H.R. 4282, the Native American Diabetes Prevention and Control Act of 1986, was introduced by Representative Pat Williams and 20 cosponsors in the House of Representatives on February 27, 1986. The bill has been referred to two House Committees: Interior and Insular Affairs, and Energy and Commerce. No hearings have been scheduled.

Copies of S. 1988 were sent to tribal chairmen for their review and comment. More than 20 tribes responded either by letter or telephone expressing their strong support.

Committee Recommendations and Tabulation of Vote

The Select Committee on Indian Affairs, in open business session on May 14, 1986, with a quorum present, recommends by a unanimous vote that the Senate pass S. 1988 as amended. The amendments appear on page 1 of this report and are explained below.

Explanation of Proposed Amendents

The Title of the bill is changed to "Native American Diabetes Prevention and Control Act of 1986."

Sec. 3 is a new provision defining Native Americans, Native Hawaiians, Secretary, Area Office and Service Unit.

Sec. 5(a)(2) is a new provision that directs the Secretary to implement a program to screen all patients receiving health services from the IHS especially the high-risk individual for diabetes.

Sec. 5(d)(2) is a new provision directing the Secretary to employ at least one diabetes control officer in each Area Office.

Section-by-Section Analysis

Section 1. *Title,* "Native American Diabetes Prevention and Control Act of 1986".

Section 2. *Findings and Purpose,* Sets forth Congressional findings of the high prevalence of diabetes among Native Americans; that 40% of Native American adults have chronic diabetes; that serious complications result when left untreated; that diabetes is the second leading reason for out-patient visits by Native Americans to IHS facilities; that health care costs will increase significantly if HHS through IHS fails to develop early prevention, diagnosis and treatment of diabetes; that the existing seven model diabetes clinics serve only 10% of the IHS service population; and that the outreach services and conveyance of effective treatment strategies of model diabetes clinics need to be implemented.

Section 3. *Definitions,* Sets forth the definitions of terms used n this Act including the meaning of Native American, Native Hawaiian, Secretary, Area Office, and Service Unit.

Section 4. *Study of Diabetes Among Native Americans,* Directs the Secretary of Health and Human Services to determine the incidence of diabetes among Native Americans; to determine the activities of the IHS in the prevention, treatment, and control of diabetes; to determine government expenditures in treating long-term complications of diabetes and to make an inventory of all resources that can prevent, treat and control diabetes.

Section 5. *Diabetes Care Program,* Within 18 months after enactment of this Act the Secretary is directed to implement programs to expand the diabetes control program, to conduct a thorough diabetes screening of all patients in the IHS with special emphasis on high-risk groups, and to conduct education and training among health care providers on the current methods of diabetes prevention, diagnosis and treatment.

Also, section 5 directs the Secretary to promote coordination and cooperation between health care providers and to fund joint Federal and Tribal health diabetes programs. It also directs the Secretary to maintain the seven model diabetes clinics and to establish

five additional model diabetes clinics; the Secretary is further directed to employ at least one diabetes control officer in each area office.

Section 6. *Data Collection and Analysis,* Within two years after enactment of this Act, the Secretary is directed to develop a standardized system of collecting, analyzing and reporting data regarding diabetes designed to facilitate dissemination of information to the Native communities and health care professionals.

Section 7. *Research,* Directs the Secretary to require each agency and unit of the Department of Health and Human Services to conduct research in the areas of diagnosis, prevention and treatment of diabetes and to coordinate such research with other agencies conducting research relating to diabetes and its complications.

Section 8. *Regulations,* Directs the Secretary to prescribe regulations necessary to carry out the provisions of this Act.

Section 9. *Authorization of Appropriations,* Authorizes such sums as may be necessary to carry out the provisions of this Act.

Cost and Budgetary Considerations

The cost estimate for S. 1988, as amended, as provided by the Congressional Budget Office is outlined below:

U.S. Congress,
Congressional Budget Office,
Washington, DC, May 22, 1986.

Hon. Mark Andrews,
Chairman, Select Committee on Indian Affairs, U.S. Senate, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the attached cost estimate for S. 1988, the Native American Diabetes Prevention and Control Act of 1985, as ordered reported on May 14, 1986.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,
Sincerely,

Rudolph G. Penner,
Director.

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

1. Bill number: S. 1988.
2. Bill title: Native American Diabetes Prevention and Control Act of 1985.
3. Bill status: As ordered reported on May 14, 1986.
4. Bill purpose: To establish a program for the prevention and control of diabetes among Native Americans.
5. Estimated cost to the Federal Government:

[by fiscal years, in millions of dollars]

	1987	1988	1989	1990	1991
Estimated authorization level:					
Study	0.2	0.1			

	1987	1988	1989	1990	1991
Diabetes care Program:					
Screening	0.2	0.2	0.2	0.2	0.2
Training	2.0	2.1	2.1	2.2	2.3
Model clinics	1.0	1.0	1.1	1.1	1.2
Additional IHS personnel	.8	.8	.9	.9	.9
Educational materials	.5				
Diabetes control officers	.9	.9	1.0	1.0	1.0
Subtotal	5.4	5.0	5.3	5.4	5.6
Data collection	2.0	2.1	2.1	2.2	2.3
Research coordination	.1	.1	.1	.1	.1
Total estimated authorization level	7.7	7.3	7.5	7.7	8.0
Estimated outlays:					
Study	.2	.1			
Diabetes care program	4.0	4.8	5.2	5.3	5.5
Data collection	1.5	2.0	2.1	2.1	2.2
Research coordination	.1	.1	.1	.1	.1
Total estimated outlays	5.8	7.0	7.4	7.5	7.8

The costs of this bill fall within function 550.

BASIS OF ESTIMATE

The bill authorizes such sums as may be necessary to carry out the activities described. CBO assumes all authorized amounts are fully appropriated at the beginning of each fiscal year. Outlays are estimated using spendout rates computed by CBO on the basis of recent program data. Authorization levels are subject to subsequent appropriations action.

S. 1988 has four parts that would result in costs to the federal government. The bill authorizes the Secretary of Health and Human Services to conduct an 18 month study on the incidence of diabetes among Native Americans and how to reduce it. The study would include the fiscal impact on the federal government of treating the long-term effects of diabetes and include an inventory of all health care resources available to treat and prevent diabetes among Native Americans. Costs of the study are expected to be about $300,000 for the 18 months.

The bill also authorizes the Secretary to implement a diabetes care program. As part of this program, diabetes screening would be provided for those receiving services from the Indian Health Service (IHS) at an estimated cost of about $200,000 each year. Training would be provided for health care providers and community health representatives on prevention, diagnosis, and treatment of diabetes. CBO estimates the cost of this training to be about $2 million in each year. Costs include wages and travel for trainers and per diem and travel for trainees. This estimate assumes 80 hours of training would be provided to all community health representatives and to one person from each health care facility.

The diabetes care program would also include establishing five new model diabetes clinics in areas specified in the bill. The Indian Health Service currently supports seven such model clinics at a cost to the Service of about $200,000 for each clinic each year. The majority of this covers salaries for the health care professionals

and others operating the clinic. If the five new clinics provide the same level of services as the current clinics, additional costs to the federal government could be about $1 million each year.

The bill authorizes maintenance of the necessary IHS personnel to implement the Act and to administer the diabetes care program. CBO estimates that at least an additional 40 full-time equivalents [FTE's] would be needed to implement and administer the diabetes care program. The five new model diabetes clinics would require an additional 25 FTE's. The model clinics currently operating have an average of 5 FTE's employed at each site. Costs for these 25 additional FTE's have been included in the above estimate for the model diabetes clinics. The remaining 15 FTE's could be required to administer the diabetes care program. The alcoholism program currently operated by IHS is managed by 5 FTE's at the agency office and about 10 FTE's in the service areas. If a similar level of program administration is used for the diabetes care program, an additional 15 FTE's would be needed at a cost of about $800,000 each year.

The Secretary is also authorized to develop health education information concerning diabetes for Native American communities and schools. If $1,000 were spent for the development and provision of diabetes educational materials at each Bureau of Indian Affairs contract school and at public schools with significant Native American populations the cost would be about $500,000. The bill would also authorize salary and overhead for at least one full-time diabetes control officer in each area office. CBO estimates the cost of this provision to be about $1 million in each year.

There are several aspects of the diabetes care program mentioned in the bill for which CBO has shown no costs in this estimate. For example, the bill mentions that the diabetes care program shall be designed to enable all service units of the IHS to effectively treat diabetes and to ensure that proper continuing health care is provided. The bill also states that the Secretary shall fund joint projects concerning diabetes involving federal and tribal health care facilities and Native American communities. CBO has no basis to estimate the cost of several such activities mentioned in the bill or the level of federal involvement that might be undertaken by the Secretary to comply with the bill language.

The bill also authorizes the Secretary to develop a data collection and analysis system relating to diabetes. The federal government currently operates a similar system that collects and analyzes data on smoking at a cost of about $2 million each year. Similar costs could be expected to result from the diabetes data collection system.

Finally, the bill authorizes the Secretary to require each agency within HHS conducting research on diabetes to give special attention to research concerning Native Americans and to coordinate that research within HHS. CBO cannot anticipate how the Secretary might require agencies to "give special attention" to this type of research or the resulting costs. Coordinating diabetes research relating to Native Americans could be accomplished by hiring a coordinator to monitor the department's efforts at a cost of less than $100,000 each year.

6. Estimated cost to State and local government: The budgets of state and local governments would not be affected directly by the enactment of this bill.

7. Estimate comparison: None.

8. Previous CBO estimate: CBO prepared an estimate on April 14, 1986, for S. 1988 as introduced. The version of the bill ordered reported would expand the scope of the Diabetes Care Program.

9. Estimated prepared by: Carmela Dyer.

10. Estimate approved by: James L. Blum, Assistant Director for Budget Analysis.

Regulatory Impact Statement

Paragraph 11(b) of Rule XXVI of the Standing Rules of the Senate requires each report accompanying a bill to evaluate the regulatory and paperwork impact that would be incurred in carrying out the bill. The Committee believes that S. 1988 will have no regulatory or paperwork impact.

Executive Communications

The pertinent communication received by the Committee from the Department of Health and Human Services is set forth below:

Statement on S. 1988 of Everett R. Rhoades, M.D., Director, Indian Health Service, before the Senate Select Committee on Indian Affairs, April 15, 1986.

Mr. Chairman and members of the Committee: I am Dr. Everett Rhoades, Director of the Indian Health Service [IHS]. With me are Dr. Dorothy Gohdes, Director of the IHS Headquarters Diabetes Program, Mr. Bruce Leonard, Public Health Educator in IHS, and Dr. Peter Bennett, Chief, Phoenix Epidemiology and Clinical Research Branch NIH. We are pleased to be here today to discuss S. 1988, the "Native American Diabetes Prevention and Control Act of 1985". The bill deals with the very serious problem of diabetes in the Indian community—the incidence of which has been increasing in recent years. Though diabetes can be treated and usually controlled it is an insidious condition with serious potential consequences including blindness, vascular obstruction and kidney failure.

We believe that the authorities contained in S. 1988 are not needed to continue or improve IHS diabetes programs. Furthermore, the bill could potentially narrow the focus of Federal efforts to improve the health status of Indians by drawing limited funds from other priority projects. For these reasons we do not support S. 1988. I would like to make some general comments about diabetes, its impact on the Indian community, and what the IHS is currently doing about it.

Non-insulin-dependent diabetes [NIDDM] or Type II Diabetes is a major health problem in American Indian communities. Since 1940, the incidence of diabetes has increased dramatically in many tribes. Current theories suggest that American Indians and certain other populations carry a "thrifty gene" which was advantageous during periods of alternating feast and famine. With sedentary lifestyles and high fat food sources, people with the "thrifty gene" are prone to obesity and Type II Diabetes. Precise data are available

for the Pima Indians because of a continuing longitudinal study of diabetes conducted by the National Institutes of Health.

In recent years the complications of diabetes have become more frequent as the number of patients with longstanding diabetes has increased. In fiscal year [FY] 1983, 76 percent of lower extremity amputations done by IHS or under contract were performed on patients with diabetes. The comparable figure for lower extremity amputations in the overall United States population is 50 percent.

Data on diabetes and end-stage renal disease [ESRD] in American Indians reveal a growing problem. In the states of Arizona and New Mexico, the renal failure rate for American Indians is 3.5 times the rate for whites. Fifty percent of the Indian ESRD patients have diabetes. Figures for the U.S. population show that 25 percent of ESRD is diabetes related. Exact figures for blindness related to diabetes are not available, but the Gallup Indian Medical Center treated 24 patients with proliferative diabetic retinopathy in the first quarter of FY 1986. In the Pima study, 46.8 percent of patients with diabetes for 10 or more years had some form of retinopathy. Of the direct IHS and contract discharges in FY 1983 for ischemic heart disease, 29 percent also had diabetes listed as a discharge diagnosis. The rate for first cataract surgery was 2.2 times higher in Pima diabetic patients than non-diabetic Pimas.

Periodontal disease associated with diabetes is not being described among Indians. Loss of teeth for those over 75 occurred in 33 percent of diabetic Pimas but only 2 percent of non-diabetics. Perinatal mortality for the 1970's for pregnant diabetic Pimas was 25.5 percent compared to 1.2 percent for normal pregnancies.

The rate of congenital anomalies was 3.8 percent in normal and prediabetic pregnancies compared to 19 percent in diabetic pregnancies. Experience among the Pimas suggest that careful metabolic control of diabetic women during pregnancy improves perinatal mortality markedly.

Standard morbidity and mortality measurement confirm that the diabetes problems of the Pima are generally applicable to the overall Indian population. The age-adjusted diabetes death rate (per 100,000 population) for U.S. all races in 1982 was 9.6 when the comparable rate for American Indians residing in IHS service areas was 25.5 (1981–83). The age-adjusted rate of annual hospital days per 10,000 population for the IHS service area was 315.6 (1982–83) compared to 275.0 (1983) for the U.S. The age-adjusted discharge rate per 10,000 population for the IHS service area was 39.8 (1982–84) compared to 29.1 (1983) for the United States.

The number of outpatient visits for diabetes has been steadily rising for 15 years. In FY 1981, 25,970 patients visited IHS facilities for diabetes. By 1984, 30,729 were seen. Among the Pima Indians the prevalence of diabetes increased 42 percent between 1967 and 1977. These trends are expected to continue. Morbidity and mortality will probably grow despite all our efforts, because the numbers of patients with longstanding poorly controlled diabetes will rise. The incidence of diabetes has increased by one-third among the Pimas comparing 1965–74 with 1975–84. We are concerned that other Indian communities will see comparable increases.

The IHS has in place a significant diabetes prevention and treatment program. It began in 1979 with the development of 5 model

care sites. Since then, the program has developed along several lines. Additional model sites have been added and several types of outreach activities have been initiated to improve the care and prevention of diabetes throughout IHS.

The original five model projects were developed in different types of facilities in different settings so that experience gained in the sites could be applied in a wide variety of service units. Most teams consist of nursing, nutrition, and physician assistants. Several sites have physicians. The teams work as an integral part of the service unit. A brief description of each follows:

(1) The Ft. Totten Service Unit serves about 3,330 patients on the Devil's Lake Sioux Reservation in North Dakota. The diabetes team visits homes and works in a small clinic. A consultant endocrinologist from the University of North Dakota holds clinics periodically. Currently there are 165 patients including 5 amputees, 1 dialysis patient, 2 with end stage renal disease [ERSD] not receiving dialysis, and 4 have had laser therapy. 32 percent of the diabetic patients are hypertensive. In FY 1984 they saw 15 new patients and 17 in FY 1985.

(2) The Winnebago-Omaha, Nebraska Diabetes staff works with the Omaha Tribal Clinic and the Winnebago Hospital and Health Department. Within a population of 4,593 there are 430 patients with diabetes including 23 amputees, 19 dialysis patients, and 27 who have received laser treatment. 32 percent of the diabetic patients are hypertensive. There were 41 new patients in 1984 and 43 in 1985. The team has developed an approach to diet counseling tailored to this community. The materials to support this approach are now in draft for wide distribution in IHS.

(3) The Claremore team follows 1,000–1,200 active patients in eastern Oklahoma from a multiservice medical center. There is not a distinct reservation but the service population is about 63,000. In 1984 the team saw 130 new patients. This increased to 169 in 1985. A day care program provides intensive education. Followup is carried out in high flow clinics. This team assists other clinics in establishing and evaluating diabetes care.

(4) The Albuquerque team follows 660 patients with diabetes from a service population of 17,813. These patients live in Pueblo villages, the Alamo Navajo Reservation, and the urban environment of Albuquerque. These are 7 amputees, and 13 who have had laser treatment. There are 4 dialysis patients from the villages. 32 percent of the diabetic patients are hypertensive. In 1984 there were 92 new patients to the program. There were 86 new patients in 1985.

(5) Sacaton Service Unit is the site of the ongoing National Institutes of Health [NIH] study of diabetes. As of September 1985, it has been reported that half the adults over 35 are known to have diabetes. The diabetes team has a current census of 359 and has had contract with 311 more. There were 65 new patients in 1984 and 86 in 1985. Out of a total population of about 10,000, our latest figures indicate there are 48 patients on dialysis.

Two additional projects were begun in the summer of 1985. In Washington State, the Lummi Service Unit is developing a program with computer based flow sheets for following diabetic patients. Cooperative efforts with other Portland Area service units

are an integral part of the initial planning. In Maine, the tribes are developing a strong preventive/screening program under tribal auspices.

As the Diabetes Program developed, many health care providers approached staff with questions about Type II Diabetes and Indians. There were widespread misunderstandings about complications. The staff become involved in training and technical assistance. A two day course on Diabetes in Indians was developed using faculty from major universities and the IHS program. In FY 1985 there were 6 cooperative workshops for health care professionals involving 500 people from 16 states. Community Health Representative training was initiated. In FY 1985 staff were involved in 42 site visits in 13 states. The Winnebago Service Unit has a training rotation for nurses and dietitians. IHS diabetes training has incorporated materials or faculty from the American Diabetes Association [ADA], the National Diabetes Advisory Board [NDAB], and the University of Michigan Diabetes Research and Training Center [DRTC].

In FY 1984 and FY 1985 Service Units submitted proposals for seed monies to improve diabetes care at their service unit. These were reviewed by a technical panel and ranked. Money was distributed to the top ranking proposals. Attached is a listing of these projects.

Several Areas have now designated disabetes control officers. Diabetes control officers collect surveillance data about diabetes and supervise audits of care practices. Educational materials and standards of care are disseminated to all service units propmptly. Orientation and ongoing training in diabetes is coordinated by the diabetes control officers.

The Headquarters Diabetes Program provides technical supervision for the model sites, coordinates training, and has identified barriers to care in IHS. The Headquarters program works with the NDAB, National Diabetes Information Clearing house [NDIC], DRTC, Center for Disease Control [CDC]. Picture diet manuals for Southwestern and Plains Indians foods are now available. A CHR training package is under development along with other diabetes educational materials.

In summary, we believe that the IHS is already directly its efforts toward the goals of S. 1988. Model sites develop comprehensive approaches to preventive health services in "typical" settings. The expertise in diabetes is shared through training programs and on site technical assistance. Seed monies allow other service units to improve their diabetes services. Indian oriented materials are developed and disseminated through diabetes control officers. Current information about the extent of diabetes and its complications is collected by diabetes control officers. Indian communities can obtain information and technical assistance from the program as needed. The authorities contained in S. 1988 are redundant or unnecessary or would in some instances direct limited resources from higher priority activities.

This concludes my prepared statement. We will be happy to answer any questions you may have.

ONE-TIME INITIATIVE FUNDING—FISCAL YEAR 1986

All proposals will determine the incidence and prevalence of diabetes in a funded group. Those funded will design, develop and operate a diabetes screening clinic and produce a detailed final report of their conclusions.

Proposals awarded

800, Red Lake, MN	$4,000.00
662, Cass Lake, MN	7,486.00
600, Tahlequah, OK	7,327.40
562, White Earth, MN	7,500.00
550, Oneida, WI	4,770.00
528, Sanders, AZ	1,350.00
485, Seattle, WA	7,500.00
471, Shiprock, NM	7,450.00
471, Crownpoint, NM	7,498.00
450, Tollhouse, CA	7,133.00
442, Hoganasburg, NY	7,490.00
387, Pine Ridge, SD	4,491.00
357, Atmore, AL	7,500.00
342, Trenton, ND	2,200.00

One-time awards fiscal year 1984

Ft. Berthold, ND. $14,220.00

This project established jogging trails, screened for diabetes at health fairs, developed an educational program in community schools and provided resources for aerobics instruction.

Belcourt, ND. 5,170.00

Normalize glucose control in a selected group of 20 diabetic patients through diet, activity and medication, using home glucose monitoring. Intensive nutritional teaching was provided to produce weight loss and ideal control.

White Earth, MN. 14,442.00

A general diabetic education component was provided using films, tapes and slides. A model meal program utilizing selection and preparation of foods was provided. 10% of the diabetic population was provided with glucose monitoring supplies to enhance awareness of food, exercise, and medication balance.

Fort Yuma, CA. 9,607.50

Hands on classes in meal planning and food preparation were designed and presented. Key personnel left and project was ended.

Carl Albert, OK. 20,575.00

This project utilized a non-invasive method to obtain information on diabetic vascular disease (lower extremity arterial measurement). Screening identification and referral of patients for revascularization surgery.

Portland area. 7,575.00

This project was funded to develop script and slides for a teaching series tailored for local people to illustrate desired behavior in diabetes management. This project was not successfully completed.

Rosebud, SD. 14,220.00

This project produced a home glucose monitoring program on the reservation to improve diabetes control (particularly in the pregnant patient). The project also successfully produced a number of diabetic education video tapes.

San Carlos, AZ. 14,722.00

This project built a walking/jogging trail to promote "pathway to health" for diabetic patients. A home glucose monitoring program was designed and implemented for gestational diabetic patientss to strive for tight control through better self-management. Successful program.

Narranganseтt Indian Tribe, RI. $10,892.00

The development of a video tape on health promotion in diabetes. Design and assembly of a diabetic educational kit. To train the medical staff in the use of the educational kit, blood glucose monitoring and diabetic prevention advertising program.

Tuba City (Hopi), AZ 12,929.00

Development of Hope specific diabetes teaching materials and activities. Community awareness program on diabetes.

Pierre South Dakota service unit, SD. 9,000.00

The developmenmt and coordinaiton of multidisciplinary Diabetes Team.

Leech Lake Reservation, MN 5,300.00

Development of diabetes support groups and educational programs. The implementation of a referral system between health descriptions.

Western Oregon 4,460.00

Diabetes risk reduction for students through weight reduction and nutritional counseling.

Boston Indian Council, MA. 1,275.00

Case detection through screening and GTT testing. Diabetes education including nutrition and family counseling.

Rocky Bay Health Board, MT 15,000.00

Design and implement a physical fitness program to lower risk factors of diabetes. Nutritional analysis with weight control.

Northern Cheyenne, MT 15,110.00

Re-design of the diabetes management system including clinical and education.

Crow Agency, MT 15,000.00

Diabetes retreat for newly diagnosed patients, glucose monitoring and patient education materials.

Warm Springs, OR 1,900.00

Aerobic exercise program for diabetics including effect on blood sugar control.

Changes in Existing Law

In compliance with subsection 12 of Rule XXVI of the Standing Rules of the Senate, the Committee notes that no changes in existing law are made by S. 1988 as amended.

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Calendar No. 663

99TH CONGRESS
2d Session

SENATE

REPORT
99-311

ERRATA

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MAY 29, 1986.—Ordered to be printed

Filed, under authority of the order of the Senate of May 21 (legislative day, May 19), 1986

Mr. ANDREWS, from the Select Committee on Indian Affairs, submitted the following

REPORT

[To accompany S. 1988]

CORRECTIONS

On page 4, paragraph one should read:

"The Select Committee on Indian Affairs, in open business session on May 14, 1986, with a quorum present, by a vote of four in favor and one opposed, recommends that the Senate pass S. 1988 as amended. Senators voting in favor were Senators Andrews, Abdnor, Melcher and Inouye; opposed was Senator Gorton. The amendments appear on page 1 of this report and are explained below."

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